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IN THE CIRCUIT COURT OF
THE 11TH JUDICIAL CIRCUIT
IN AND FOR DADE COUNTY, FLORIDA
GENERAL JURISDICTION DIVISION
CASE NO. 94-08273 CA (22)

HOWARD A. ENGLE, M.D.,
et al.,
Plaintiffs,
vs.
R.J. REYNOLDS TOBACCO
COMPANY, et al.,
Defendants.
_____/

Miami-Dade County Courthouse
Miami, Florida
Monday, 2:00 p.m.
November 8, 1999

TRIAL - VOLUME 389

The above-styled cause came on for trial before the Honorable Robert Paul Kaye, Circuit Judge, pursuant to notice.

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TAMiami,JFlorida WH305-358-9047N

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APPEARANCES:
STANLEY M. ROSENBLATT, ESQ.
SUSAN ROSENBLATT, ESQ.
On behalf of Plaintiffs
WINSTON & STRAWN
DAN WEBB, ESQ.
BRADLEY LERMAN, ESQ.
On behalf of Defendant Philip Morris
DECHERT PRICE & RHOADS
WILLIAM DODDS, ESQ.
On behalf of Defendant Philip Morris
COLL DAVIDSON SMITH SALTER & BARKETT
NORMAN A. COLL, ESQ.
On behalf of Defendant Philip Morris
ZACK KOSNITZKY
STEPHEN N. ZACK, ESQ.
On behalf of Defendant Philip Morris
CARLTON FIELDS WARD EMMANUEL SMITH & CUTLER
R. BENJAMINE REID, ESQ.
DOUGLAS J. CHUMBLEY, ESQ.
On behalf of Defendant R.J. Reynolds
JONES, DAY, REAVIS & POGUE
JAMES JOHNSON, ESQ.
JAMES YOUNG, ESQ.
DIANE G. PULLEY, ESQ.
On behalf of Defendant R.J. Reynolds
KING & SPALDING
GORDON SMITH, ESQ.
On behalf of Defendant Brown & Williamson
CLARKE SILVERGLATE WILLIAMS & MONTGOMERY
KELLY ANNE LUTHER, ESQ.
On behalf of Defendants Liggett Group
and Brooke Group

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APPEARANCES (Continued)

SHOOK HARDY & BACON
KENNETH J. REILLY, ESQ.
WILLIAM P. GERAGHTY, ESQ.
On behalf of Defendant Brown & Williamson
JAMES T. NEWSOM, ESQ.
On behalf of Defendant Lorillard
GREENBERG TRAURIG HOFFMAN LIPOFF ROSEN & QUENTEL
DAVID L. ROSS, ESQ.
On behalf of Defendant Lorillard
MARTINEZ & GUTIERREZ
JOSE MARTINEZ, ESQ.
On behalf of Defendant Dosal Tobacco Corp.
and Tobacco Institute
KASOWITZ BENSON TORRES & FRIEDMAN
AARON MARKS, ESQ.
On behalf of Defendants Liggett Group
and Brooke Group
ADORNO & ZEDER
ANTHONY UPSHAW, ESQ.
On behalf of Defendant Brown & Williamson
DEBEVOISE & PLIMPTON
JOSEPH P. MOODHE, ESQ.
On behalf of Defendant Council for Tobacco Research

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I N D E X

E X H I B I T S

PLAINTIFFS' EXHIBITS	OFFERED PAGE	ADMITTED PAGE	FOR ID PAGE
None			

E X H I B I T S

DEFENDANTS' EXHIBITS	OFFERED PAGE	ADMITTED PAGE	FOR ID PAGE
None			

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(Whereupon, the following proceedings were had:)

THE COURT: Are we ready?
MR. REILLY: Yes, Your Honor.
THE COURT: Okay. Bring the jury out.
MR. REILLY: Your Honor, I have no other questions.
THE COURT: You're not going to have any other questions?
MR. REILLY: No, sir.
THE COURT: You'll say that in front of the jury.
(Discussion off the record.)
(The jury entered the courtroom.)
THE COURT: All right. Have a seat, folks.
All right. We were on the defense cross when we broke for lunch.
You may proceed, sir.
MR. REILLY: No further questions, Your Honor.
THE COURT: All right. No further questions from the defense.
Redirect.
MR. ROSENBLATT: Yes, Your Honor.

REDIRECT EXAMINATION

BY MR. ROSENBLATT:

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Q. I started making notes, Dr. Sidransky, when Mr. Reilly started questioning you, so I'm going to go kind of in the order in which he questioned you, in terms of the subjects I'm going to cover.
Now, I think he started out by asking you about how you happened to get involved in this case, and he asked you if Dr. Feingold, who is a, as you know, a Miami pulmonologist, whether Dr. Feingold had asked you to become involved as a witness in this case.
And what was your answer to that?
A. As I recall, again, it was that Cliff

Douglas
12 who had called me, not Alan Feingold, about
becoming
13 involved in the case.
14 Q. Okay. Cliff Douglas is a lawyer?
15 A. Correct.
16 Q. Practices in Michigan?
17 A. That's what I understand.
18 Q. Okay. And then I think you were asked
if you
19 had ever testified in a tobacco case where Dr.
Feingold
20 also testified, and I believe you said the Maddox
case?
21 A. Correct.
22 Q. Okay. Where was the Maddox case, what
city?
23 A. It was in Jacksonville.
24 Q. I was not involved in that case, was I?
25 A. You were not involved, no.

1 Q. Now, then I think you were asked a
couple of
2 questions about whether you ever gave a lecture to
3 lawyers on subjects which would be related to
tobacco
4 and health, and you said you did one time?
5 A. Correct.
6 Q. And where was that?
7 A. That was in New Orleans, and at the
request
8 of Woody Wilner, a lawyer from Jacksonville, had
he
9 asked me if I would speak on the subject of
genetics
10 induced by tobacco smoke, in the particular tumor
11 types, and that's essentially what I did.
12 Q. Okay. To the best of your knowledge, I
was
13 not at that meeting and we never had any contact
at
14 that meeting?
15 A. No. I never met you until I flew in
16 yesterday.
17 Q. Okay. Now, the chart that Mr. Reilly
was
18 using, where he was discussing with you what a
doctor
19 needs to do to become board-certified in
pathology,
20 what a doctor needs to do to become
board-certified in
21 internal medicine or oncology, where you are
22 board-certified, at a teaching institution such as
23 Shands, which, as you know, is connected with the
24 University of Florida School of Medicine, is it
your
25 presumption that the pathologists who interpreted

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Farnan's pathology slides there, who were involved with her care and who were talking to her treating physicians, that they were board-certified in the field of pathology?

A. Well, again, I think going through the same arguments that we went through with Mr. Reilly would only make sense; that, generally, every single pathologist in any major institution that signs out on the pathology has to be board-certified.

Q. And what you've told us on direct examination, that based on your review of the records, those board-certified pathologists never uttered a syllable about BAC, did they?

A. Well, that is correct, both in the cytology specimens, which we talked about earlier today, taken from the original biopsy, the CT-guided biopsy, as well as all of the other pathology reports, which included the pathology of the left tumor, the pathology for the right tumor and then the metastasis to the brain.

Q. Now, although you are a cancer specialist and board-certified in oncology, you are not specifically board-certified in the field of pathology, correct?

A. That is correct.

Q. So, how is it with that credential being lacking, that you are, in fact, a full professor of

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pathology at Johns Hopkins University School of Medicine?

A. Well, I would say two things. I would say it's kind of analogous to learning how to fly and flying in the Air Force, and then coming back into the United States into the civil service and having to get a civil license to be able to fly.

What happens is that when you're at an institution and you're practicing in the area of pathology, albeit not as a service, so you're not billing for it, there is no requirement for me to go get board certification.

What happens over a period of time in an institution like Hopkins is board-certified pathologists, who are obviously all members of the department of pathology, recognized expertise that you've developed, in this case the expertise that I developed, particularly in head and neck cancer and lung cancer, the tumor types we're talking about today, particularly lung cancer, and those board-certified pathologists then essentially ask you to and certify you within their department to be able to work within their department and be able to work on pathology.

So, in a sense, it's not the general certification that people go through to get a pathology

equivalent, but I would say that it is essentially another way in academics that you can get the same type of expertise acknowledged, and I think that's what it shows.

Q. So, in other words, the people making the judgment or who enabled you to function as a professor of pathology at this medical school are, in fact, board-certified pathologists?

A. Correct.

Q. When you practiced hands-on oncology -- and by the way, when you were an oncologist at Johns Hopkins, your patients came from where?

A. Well, Johns Hopkins Hospital is essentially an inner-city hospital, and we treat the surrounding population. We also have quite a few people that fly in from around the country, as well as internationally, to be treated at Hopkins. So, it's really quite a flavor of different -- people from different backgrounds and different situations.

Q. Now, when you were treating patients yourself, did you have occasion to actually study the

22 slides of your patients under a microscope and function
23 as a pathologist?
24 A. Well, I think we went through that earlier,
25 but that is the case in almost -- in almost every

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1 single case; that is, that we would see the patients,
2 either in some circumstances we would draw the material
3 ourselves, especially from bone marrows or sometimes
4 from peripheral lymph nodes to look at the slides, but
5 we would always go to the department of pathology and
6 look at the slides ourselves, because it's so important
7 in knowing how to treat the patient and what that
8 prognosis is for that patient.
9 Q. Does your work in molecular pathology
10 cause you to interact on a frequent basis with
11 board-certified pathologists?
12 A. Well, that is part of the reason why we're a
13 part and why I am a professor in pathology. We work
14 with them all of the time.
15 Basically, virtually all our studies involve
16 the dissection of tissue, taking of slides, looking at
17 it under the microscope, identifying certain cell types
18 or patterns, extracting the material to make DNA, the
19 part that's inside the cell, looking at the genetic
20 changes in those cells.
21 And, again, pathology is an integral part of
22 everything that we do, and we work on every single one
23 of our studies with the pathologist as well, as a
24 general rule.
25 Q. Either at the present time or when you were a

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1 treating oncologist, did you, yourself, have occasion
2 to take tissues or cells, you know, to gather them
3 from the patient, or was that always done by the

pathologist?
A. No. We also had the opportunity to do it, and we still do it from time to time, mostly in the outpatient setting as we talked about, where we take the opportunity in certain diseases where we want to stage patients, see if there are tumor cells in certain stages like the bone marrow, or, again, if there is an easily accessible mass we want to look at ourselves, we will do that as well.
Q. As a practical matter, you pick up a hospital chart, and whether it's Dr. Murphy or Dr. whoever who's listed as a pathologist, the way it works, does that pathologist, who's deciding whether a given tumor is cancerous and deciding what type of cancer, does that pathologist, in your experience, have direct patient contact?
A. That's very unusual. That's one of the reasons why it's so important to interact with pathologists and go and see the slides together, because what the pathologist generally receives is a lot of material from different places in the hospital. He's not seeing the patients

Oftentimes there's histories that are given to them that are incorrect. I mean, if you look at the paper that we admitted as evidence, there's a much larger smoking history than most of the treating physicians saw in Ms. Farnan of 75 pack-years.
You can oftentimes, from some mistakes that are transmitted to the pathologist -- and it's one of the reasons why it's very important for treating physicians, whether they be oncologists or otherwise, to interact with the pathologist and make sure that they understand what the clinical scenario is and what the patient has, from a pathologic point of view.
Q. So, is it fair to say that in most

instances,
probably, a patient wouldn't even know the name or ever
have met the pathologist?
A. That is true.
Q. Just like a radiologist?
A. That is correct.
Q. The doctor who is interpreting X-rays?
A. Right. That would be very unusual. There
are some pathologists now that try to go out to the
clinic and gather the material themselves for some of
the cytology specimens, and the patient may come in
contact, or in the case of the CT-guided biopsy, the
patient may come in contact with either the radiologist

or a pathologist that's there looking at the slides to
make sure the material is adequate.
Q. Now, would that same relationship hold true,
or would it be a different relationship, the
relationship between a pathologist and patient, when we
talk about cytology?
A. That would be very similar, as well. The
cytologist tends to go out a little bit more into the
clinical area because, as we've gotten more and more
to noninvasive techniques, where you don't have to go
under local or certainly general anesthesia where
you're put to sleep to take a piece of tissue,
the cytologists have gone out more and more into the
clinics to help ascertain whether the material that's
drawn is adequate for making a diagnosis.
So, they do sometimes go out. But most of
the time, they also see samples in a centralized
setting in the hospital.
Q. Now, you were asked if you had taken any
photomicrograph. And remind the jury, what is a
photomicrograph?
A. Well, when you're looking at slides, you can
take pictures. So, you have these large number of
slides, I don't know, 40 something, or whatever you had
in this case, from different parts of the

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tumors that we had, and you go through them and you basically establish a diagnosis. You can go back, while you're doing this, identify certain areas of the -- of the material and decide that you wanted to show it to somebody. So you take a picture of it, and it's essentially -- it can be put on film and you can make reproductions of it. You can blow it up. You can show it. You can obviously use it to display what you're seeing.

Q. Now, when you had access to the slides, both the pathology slides and the cytology slides, you chose not to take any photographs, correct?

A. Correct.

Q. Why not? Would they have been useful to you, do you feel, in terms of rendering opinions in this case?

A. I don't think so. And the reason is that you have to remember, when you're looking at a tumor and you have all these different slides and you're looking at it in high-power, hundreds of different fields -- because when you go into high power, you're going to be looking very carefully at each section of the slide, the diagnosis established by looking at all of the cells and understanding what are the variations between them, what is the type of cell that you're looking at,

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what is this cancer, and it's more than five or six criteria that we listed earlier. It's really probably hundreds of different criteria.

You know, when they've tried to reproduce something simple like the pap smear, machines that

can
read what humans read, they program 30 or 40 different
characteristics into the cells, and yet when it all
spits it out, you still have to have a person look at
it to make sure, because you just can't define enough
characteristics to replace the experience of a person
that's looking through this and knows what they're
looking for.
The problem is that if you were to take a
picture of the world, let's say you were on a space
ship, and you would take a small area of the world and
show mountains, you can conclude from that that the
whole world is full of mountains. Well, in truth,
two-thirds of it is completely water.
The problem is that with micrographs, you can
basically show whatever you want. Tumor cells are
exactly what I said. Like 600-pound gorillas, they do
all kinds of bizarre things: They spread out
differently through tissues; they can form
bizarre shapes. They can form very plain shapes.
As they go through that, you're looking at

that slide to make an accurate diagnosis. Somebody can
take one particular area, blow it up, and say, "Hey,
this looks like something," but that's not the correct
diagnosis.
So, I don't see any value in taking a few
selected slides and saying, "This is what I saw,"
because in the end, the only thing that really counts
is you got an opportunity to look at a lot of material,
sufficient material in your experience, to be able to
make an accurate diagnosis; and I believe that I had
more than adequate material here, as did the treating
pathologist and the treating cytopathologist,
obviously, to make the same diagnosis, and that is,
this is not BAC.

Q. And is that why, for example, you were asked some questions about staining and whether you could do some or more sophisticated tests on the slides you had, but you chose not to do them, is your answer the same?

A. Well, my answer would be the same. You can do all kind of different tests: you can stain for different proteins, you can even do molecular studies, but I don't think it would change anything we're talking about here.

These are poorly differentiated cells. They do not look like classic BAC. This is not a tumor

that -- Mrs. Farnan does not have a tumor that is BAC. This is a tumor that is associated and caused by cigarette smoking.

Q. And, Doctor, wherever one chooses to put bronchioalveolar carcinoma, whether as a subset of adenocarcinoma or as a separate category, did Mrs. Farnan have BAC?

A. Well, you know, I think it comes down to something that's very familiar to us as physicians, and that is, that we have lumpers and we have splitters, when we try to do all this kind of stuff. There are some people that would rather have one or two categories of anything and not make it any more complicated, and there are others that would try to distinguish a hundred different small divisions and say each one of them is important.

The only important thing here is that there is a very rare disease called bronchioalveolar carcinoma, makes up less than one out of every hundred tumors that we look at. It is a distinct clinical entity. It presents differently. It progresses differently and looks very differently under the microscope.

It makes not one bit of a difference to me whether it's classified as an adenocarcinoma or

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something separate outside of an adenocarcinoma. That is a rare disease. That is not what Mrs. Farnan has, and the disease -- well, BAC is not always associated with smoking, but most patients with BAC still do smoke.

MR. REILLY: Objection, Your Honor. May we approach?

THE COURT: No. I don't think it's necessary at this point.

I think we're going a little bit beyond the question.

MR. ROSENBLATT: All right. Let me interrupt --

THE COURT: I'll tell you, just for the record, for the sake of the record, I'll sustain the objection as far as it goes, but change the direction.

MR. ROSENBLATT: Okay.

BY MR. ROSENBLATT:

Q. Did Mrs. Farnan have any form of BAC, whether you're dealing with a lumper or a separator, in terms of categories?

A. No. This is not BAC.

Q. And the type of lung cancer that Mrs. Farnan had was caused by what?

A. The type of lung cancer that Ms. Farnan had

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was caused by cigarette smoke.

Q. What percentage of lung cancer overall is caused by cigarette smoking?

A. Overall, it's about 90 percent --

MR. REILLY: Your Honor, this is Phase I.

A. -- is caused --

THE COURT: Yes. I'll sustain that.

BY MR. ROSENBLATT:

Q. Does the unique entity, which you've described, of bronchioalveolar carcinoma, does that ordinarily metastasize to the brain, or is that not characteristic of BAC?

A. That is not characteristic of BAC. There are

recent studies that have suggested that advanced stage BAC, like the type that Mrs. Farnan could have had, if it was, in fact, BAC, would be very unlikely to metastasize, that is, advanced stage BAC is very unlikely to metastasize to the brain; again, making it very unlikely that this disease is BAC.

Q. When oncologists talk about cancer as being invasive as opposed to metastasizing, how do they use that term? What does it mean for a particular tumor to be invasive?

A. Well, in simple terms, it means that the tumor has invaded the normal tissue. That essentially

is cancer. If the tumor is still contained within the little membrane that separates out the lining of whatever tissue you're looking at versus the deeper tissues, it's what we referred to earlier as carcinoma in situ, is that it's still contained, and that actually is not a very dangerous situation. It's very easy to remove and is unlikely to progress at all once it's been removed.

Most clinical cancers we deal with have invaded; that is, that they've already gone into adjacent tissue and the cells are spreading deeply into the tissues that are surrounding those cells. And that, by definition, is what we call invasive. Metastasis means that the cells have left and gone someplace else, other than the site where they first started, so they could spread to other parts of the lungs or they could go to the brain, et cetera.

Q. When a lung cancer, such as Mrs. Farnan's, goes to the shoulder and to the brachial plexus, is that part of what we mean when we talk about something being invasive?

A. That is certainly an invasive cancer. I mean, by definition, cells that invade into the neural cells, such as nerves, or certainly into bones, such as the shoulder, that is by definition an invasive

cancer.

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Q. In terms of the BAC entity, is being invasive or not invasive characteristic of BAC?
A. Well, I think we went through it earlier today.
MR. REILLY: Your Honor, I object. It's been asked and answered.
THE COURT: Yes. It was, I believe, both on direct and on cross.
BY MR. ROSENBLATT:
Q. Now, you were asked some questions about whether the treatment of chemotherapy or radiation therapy will change what you saw on the slides, whether they be pathology slides or cytology slides?
A. Correct.
Q. So, tell us about that, that process, and whether it has an impact or changes what you will actually see?
A. Well, again, chemotherapy and radiation therapy can certainly cause immediate changes. They can kill cells and make them look bizarre. What we have to remember here is that the pathology we have, for example, from the left lung came one month after chemotherapy and radiation had been completed.
There was no alteration in the morphology. It was very, very clear. And I have to reiterate, the

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gold standard in medicine is not cytology when you have pathology available. Looking at some slides of a few cells is never as definitive as looking at the tissue where you can see the cells and the way they interact with the cells around them.
So, when you have clear pathologies, as in this case, I basically believe that the cytology slides are almost superfluous to the whole issue here.

It's
very clear, both from the cytology and pathology slides, that this is not BAC. It's extremely clear on the pathology slides that we don't have the pattern of BAC that we talked about earlier, which grows through the alveoli and is classic for BAC.

Q. Now, when you say the chemotherapy and the radiation which ended earlier, you saw no alteration in the morphology, meaning what?

A. That is, the way the cells looked and the way that the tissue looked that was being evaluated, there was no evidence of necrosis in the areas that I looked at that would make any difference. There was very clear morphology. You could see the cells. You could see the way they sat in the tissues.

It was very clear a poorly differentiated adenocarcinoma, which was concurred by the pathologists that were seeing the slides at the same -- at the time

of the diagnosis.

Q. Now, you were asked some questions about -- I think there was a comparison made between the tumor in the left lung and then the subsequent tumor in the right lung, and I understood you to agree that either one or both of the tumors was unusual, somewhat unusual?

A. Correct.

Q. The Pancoast tumor?

A. That is correct.

Q. Does that unusualness in -- without repeating it all, does that unusualness in any way alter the opinions that you've expressed here today about it not being BAC and about the cancer having been caused by smoking?

A. Well, no. We have to remember that there's an epidemic essentially of lung cancer. I mean, there's going to be probably close to 200,000 cases of lung cancer next year.

MR. REILLY: Your Honor --
A. There's a lot of cases --
MR. REILLY: Your Honor, I --
THE COURT: I think it's a prefatory remark at this point, so as far as it goes, overrule the objection.

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Go ahead. Finish your answer, sir.
A. (Continuing) With over 200,000 cases next year probably of lung cancer, there's so many different cancers that we see in individuals that individuals vary and you see different presentations. It doesn't change the basic morphology of the cells, though. It doesn't change what you're looking at under the microscope.
When you see so many different cancer cases, you're going to get a case that has a tumor here and a tumor there, a single tumor, a tumor that metastasizes to this area. When you scrutinize each individual case, you can say it looks unusual.
When you're used to treating patients with oncology, you get into this thing that I've been talking about. Tumors do whatever they want to. That's why they're so difficult to treat. The point is when you've seen enough patients, you see virtually every patient, and it's not that surprising to us anymore. We see all kinds of patterns. We deal with it. We're still very clear to make sure the pathology is correct so that we know how to treat the patient.
Q. And as you reviewed both the slides and Mrs. Farnan's records, do I understand correctly that pathologists were involved in an analysis of the tumor

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that was in the left lung, with the tumor that was in the right lung, and then with the brain tumor?

A. Well, actually, you have four stages: You have the cytology slides, which were originally read; you have the pathology sides from the original left tumor; you have the pathology slides from the right tumor; and then those from the brain. And in all those circumstances, pathologists had an opportunity to read those slides and make a diagnosis, and none of them made a diagnosis of BAC.

Q. Now, there was some discussion about the difference between recut slides and original slides. And as I understand it, you were looking at recut slides?

A. Except for the three cytology slides which were originals and were sent to us from Shands.

Q. Okay. From your standpoint in this case, would there have been any value in your -- and you would have had to go to Gainesville, Florida from Baltimore to look at the original slides, the original pathology slides. Would that have been useful to you?

A. I don't think so. There was plenty of tumor evident in all of the recut blocks. It means that once you have -- you take the tissue and you embed it from the parafin block, so it's kind of in this square. And

this tumor sitting inside of it, you take one slide of it. That's the original.

But what it means to be recut means you go just a few microns, which is, you know, essentially almost a minuscule distance, next to it, and you take another slide.

This is all representative of the same tumor. We got an opportunity to see those. There's absolutely no difference between that and what the pathologists described. We have the same thing: poorly differentiated adenocarcinoma in the left lung

without
any evidence of BAC.
Q. Let's say a pathologist or oncologist is looking at Mrs. Farnan's pathology slides, and strictly as a hypothetical question --
A. Okay.
Q. -- let's say, makes a diagnosis of adenocarcinoma, but sees a -- by the way, you showed -- you showed the members of the jury, you know, a tiny little slide, which to laypeople looks like there's hardly anything there, but yet when we talk about the cells, how many are we talking about?
MR. REILLY: Objection, Your Honor. Leading.
A. You're talking about hundreds of thousands --

THE COURT: Wait a minute. What?
MR. REILLY: Object to the leading form of the question.
THE COURT: I don't think it's leading at all.
Overruled.
BY MR. ROSENBLATT:
Q. How many cells would we be talking about?
A. It depends whether it's a piece of tissue or cytology. In cytology, it could be hundreds of thousands. It depends on the magnification you're looking in. Even in some sections of tissues, there could be tens of thousands of cells
Q. So, in this hypothetical, if a pathologist makes a diagnosis of adenocarcinoma but sees a few cells out of the many thousands which resemble BAC, does that make it BAC?
A. Absolutely not. It goes back to the same issue we're talking about, you know, taking pictures of the world. You've got to get what you call the Gestalt; that is, the overall feeling of what you're looking at.
And when you see a poorly differentiated adenocarcinoma, and you see a few cells whose nuclei aren't that apparent, that is that the size and

shapes

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of the nuclei don't change as much, that does not make it BAC. BAC has specific diagnostic criteria, both of cytology and pathology, and there has to be a substantial amount of the tumor that has that to make the diagnosis.

A. Unfortunately, cancers do what they want to do. As they spread throughout, they change and vary in form and can do all kinds of things, but it doesn't change the overwhelming observation that this is a certain type of cancer; in this case, a poorly differentiated adenocarcinoma.

Q. Now, when you use the analogy that cancer tumors, you know, do pretty much what they want, do I understand you to mean that even with all of your expertise, and you can have board-certified oncologists, even you -- they're unpredictable, in other words, what they're going to do, if you try to predict?

A. That is correct. On a group of patients with a given type of cancer, you can get a general sense of how things are going to progress and what you want to look out for. But, again, if you see enough patients, you see all kinds of unusual presentations and progressions, and you have to keep them in mind as you go through the case.

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Q. What is the term when a pathologist or anyone would look at a slide and say -- look at a particular portion of the slide and say, "Well, that's an artifact or it could be an artifact"? How is that term used?

A. Well, again, what happens is that -- and especially in areas like cytology -- cells can spread

out. Remember, you're taking a piece of tissue, let's say, from a lump or something like that. Your cells are passing through into a fine needle, and then you squirt them out on the slide.

And so, the process of drawing them up and squirting out can cause all kinds of aggregations of cells that may not be representative of what's actually going on in the tissue bed itself. In the actual tumor there could be just little areas of cells clumping together, kind of following along the line.

All these kinds of things are things you look at when you look at a slide and you realize that they're just artifacts; they're just the way the cells are spread out because of the technique that's being used.

You look for those things and you exclude them. You don't make them a major part of the diagnosis. You basically say, "This is not relevant," and you look at the major areas where you do see things

that make sense. I mean, it's the kind of thing, again, that you just have to have the experience to look through the slides and know what you're looking for.

Q. As I'm sure you recognize, when we talk about cancer, it's very easy, you know, to get lost in detail. But let me ask you this broad question.

From the standpoint of an oncologist, from the standpoint of a group of doctors treating a given patient, is it fair to say that the bottom line, both to them and to the patient, is: Is it cancerous? And how do we treat this to give this patient the best chance at recovery?

A. Well, as somebody that does a lot of research, I would say that's the most important thing. No matter how much research you do and how many studies

you're doing on tumors and how many slides you're taking and all of the other things, you need to make sure the patient has cancer. That is the absolute first priority of an oncologist and treating physician.

You need to identify the type of cancer within reasonable certainty so that you know how to treat that patient, and then you have to proceed with treating that patient correctly. That is, by far, the most important thing that needs to be done when you're

treating a patient with cancer.

Q. From the standpoint of treating a patient, will the treatment vary depending on the diagnosis of the specific kind of cancer the patient has?

A. It can be very, very important. And it's very -- it's critical that we make the right diagnosis on pathology to be able to give the right treatment to the patient, whether it be surgery or radiation therapy, chemotherapy or, in certain circumstances, to be able to potentially consider other experimental therapies for them.

MR. ROSENBLATT: Thank you, Doctor.

THE COURT: All right, Doctor. You may step down. Thank you.

THE WITNESS: Thank you.

THE COURT: All right, folks. I think we're at a stage here where I think we're through with the witnesses for today. They went a little faster, which is good.

So, we'll break for you. I think the lawyers and I have things that we have to take up this afternoon.

So, we'll let you folks go home, and we'll be back here at the usual time, 9:15 for you, 9:30 for the court, and we'll try to work it out that way.

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Again, the same rules apply. Please stay away from any outside sources of information. And if there is anything published in any form whatsoever, just don't look at it, read or listen to.

Thank you, folks.

(The jury exited the courtroom.)

THE COURT: Have a seat, folks.

Who are you calling for tomorrow?

MR. ROSENBLATT: Dr. Petty, the pulmonologist from the University of Colorado. And in view of what happened today, Judge, I had told Mr. Webb -- I think, over the weekend, I mentioned it to him, on Sunday -- not knowing how long their cross was going to take, I'm trying to line up some lay witnesses to be available, as well.

And on Wednesday, you know, in view of what happened today, Dr. Forbes, who is a treating physician of Mr. Amodeo, is going to testify, and I need to talk with, you know, Mrs. Farnan about -- I don't have any other experts -- I mean, that's the extent of my experts this week, Dr. Petty and Dr. Forbes.

Some of the others that we had talked about, you know, are certainly not available this week. And so, the other witnesses that I would be talking about would be lay witnesses, before and after, that kind of

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thing.

THE COURT: Over the lunch hour, when I went upstairs, I found another motion in limine, this one regarding Dr. Petty, which I haven't read yet. I don't know if you got it.

MR. REID: We're going to have a problem with Dr. Petty. Dr. Petty is a pulmonologist from Phase I.

THE COURT: Yes.

MR. REID: He's a pulmonologist and he's going to come in and say: I read the medical records; it's not BAC; it's whatever it is, and he's going to give addiction opinions. And, again, it's an exact reproduction of Dr. Burns and -- because they're both pulmonologists -- on the same subject matter of the testimony of Dr. Richmond, and it's cumulative.

THE COURT: Well, as I say, I haven't read your motion.

MR. REID: Sure, and counsel today, with regard to this witness, argued that he had a specialty in something different.

THE COURT: I'm not arguing the motion, counsel.

MR. REID: Oh, no?

THE COURT: You didn't understand. Not yet.

If you want to, we'll take time off. It's

only 20 to 3:00. If you feel that --

MR. ROSENBLATT: He's on an airplane, so I couldn't do anything. I mean, Dr. Petty from Colorado, he's on an airplane.

THE COURT: But we could argue the issues.

MR. ROSENBLATT: I understand.

THE COURT: So, you want to give me some time to go upstairs and look over the motion, find out what it's all about, and we could maybe argue the issues today, so we wouldn't have to take up time tomorrow morning. I know it's short notice but --

MR. ROSENBLATT: Okay.

MR. WEBB: That's fine.

Your Honor, there's one -- that's fine. We'll do that. And there is another issue just to raise, Your Honor, and that is the -- Mr. Rosenblatt did notify me yesterday, on Sunday, about the possibility of some Amodeo-related fact witnesses, and he sent me a note on that, and I have notice of those witnesses. Although I just wanted to make sure the

Court understands, if any of them were to testify tomorrow, the notice we got on Sunday clearly would breach the 72-hour rule.

And while Your Honor -- while Your Honor has said the 72-hour rule may get breached sometimes, and I

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recognize that, and I'm looking at Your Honor's face right now, but you have to remember we went back and visited this again, Your Honor, and because we weren't going to use exhibit lists, everyone agreed that we're going to have to follow the 72-rule. And that's the problem.

And I'm not trying to carp and complain. Mr. Rosenblatt, I think, tries to keep an open line of communication with me, but it's a problem, okay? And we're going to have witnesses come up tomorrow, and I don't know whether the defense lawyers have had a chance to review their files. There are a number of lawyers that are assigned to do those witnesses.

THE COURT: Let me explain the situation to you as I see it from the Bench.

MR. WEBB: Yes, Your Honor.

THE COURT: Most lawyers that I know, including myself, are terrified of the Judge and what the Judge would do if I showed up in court and didn't have a witness to present. Okay.

MR. WEBB: Yes, sir.

THE COURT: So, we go through the whole procedure, "Oops, the witness is going to be finished earlier than I thought and I have no back-up. What am I going to do?" I understand. I've been there. We've

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all been there.

So, I think in the position of caution, counsel is saying, "Look, if really push comes to

shove, I can get a witness in, if this is the Court's position." And I can understand why he would say that. I also understand your position, not prepared for a witness that you weren't ready for by way of the time it takes to prepare for cross examination. It all is a mix that I've got to work out.

MR. WEBB: True.

THE COURT: And I understand on both sides of this issue why you take the position that you take.

I think Mr. Rosenblatt knows that I'm not that much of an ogre when it comes to this because we've been through this before, the first trial that we were in on the ETS case and also this case; that I don't burn people's feet too much when it comes to presentation of witnesses. If we didn't have a witness, we didn't have a witness. What am I going to do?

MR. WEBB: Okay.

THE COURT: On the other hand, I would like to move it along, and if it's possible, to put a witness on, and we wouldn't have to wait another 24 hours to get that witness on. I would prefer to do

that, unless it interferes, really prejudicially with some other matter.

So, we have to look at the witness and see what kind of witness we're talking about: Is it a real critical witness, noncritical, that kind of thing.

MR. WEBB: I accept that.

THE COURT: I think it really should work out some way. We can work it out.

This afternoon, unfortunately, we have a little bit of leeway to take up, so we can waste -- not waste -- instead of wasting the time, take up the time to resolve some of the legal issues that we won't have to worry about tomorrow morning.

MR. WEBB: We agree.

THE COURT: That works. Sometimes we'll

get
16 home early.
17 All right.
18 MR. ROSENBLATT: Can we have until,
what,
19 about 3:30, Judge, to come back?
20 THE COURT: Yes. Give me an hour.
21 MR. ROSENBLATT: An hour. Fine.
22 THE COURT: Well, actually, 3:30 will be
all
23 right. Try 3:30.
24 (A brief recess was taken.)
25 THE COURT: All right. Have a seat,
folks.

1 Okay.
2 MR. REID: Well, Your Honor, there's not
much
3 to add to what we have in the papers.
4 THE COURT: Yes.
5 MR. REID: Just straightforward.
6 Dr. Richmond and Dr. Burns now have both testified
7 about cause, about addiction. Dr. Sidransky just
8 testified about cause. Dr. Petty is a
pulmonologist,
9 same as Dr. Burns.
10 Dr. Petty didn't look at the slides;
didn't
11 look at -- didn't even look at all of the reports
of
12 the radiation -- radiology, rather. Essentially
he's
13 going to come in, as did Dr. Richmond, and testify
that
14 this is what -- this is what the records say. And
it's
15 cumulative. And there are other witnesses -- I
16 understand, we shouldn't talk about the later
witnesses
17 and we'll deal with those as we get to them, but
now
18 we're up to our -- this will be the fourth
witness, and
19 there's nothing special. You know, Dr. Sidransky,
the
20 argument was he's a little bit different because
he's
21 in molecular biology, and Dr. Burns, I can't
remember
22 why Dr. Burns was different -- well, I guess he
was the
23 pulmonologist, that's the reason he was allegedly
24 different from Dr. Petty.
25 So, all of the reasons that counsel has
given

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for excluding or for letting the witnesses be cumulative, we've sort of run out with Dr. Petty, and you remember, he testified in Phase I about a much broader area. And so, our basis is 403; just to permit a party to keep putting in the same words, especially when it's not based on their own independent analysis. It would be one thing if Dr. Petty had done -- if Dr. Petty had read the slides and done some actual work as a doctor and came in and testified, and if Dr. Burns had, but here it's further problematic because they're just coming in and reciting what the medical records say.

The witnesses are coming in and they're just saying: Well, the pathologists all said this, and none of them said BAC, and so in my opinion, they don't have BAC, and in my opinion, there's addiction.

So, we would suggest that Dr. Petty not be permitted to testify again.

THE COURT: All right, counsel.

MR. ROSENBLATT: Judge, just reminding you briefly, Dr. Petty did testify in Phase I. He is a world-renowned pulmonologist. He was the president of the American College of Chest Physicians.

He has been an honorary professor at medical schools all over America, all over the world.

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Dr. Petty and Dr. Burns are hardly neighborhood physicians.

Now, most fundamentally, Judge, we've been assuming all along that at worst, at worst, the same ground rules apply for Phase II that applied in Phase I; and the rule was, two experts per specialty. That was the rule in Phase I.

So, Burns is a pulmonologist, and Dr. Petty

is a pulmonologist, and they are very different. And, obviously, this is not -- counsel just totally forgets about the fact that this is a state-wide class action involving hundreds of thousands of individuals.

And the decisions the jury makes as to Mary Farnan and Frank Amodeo will have an impact on thousands of class members throughout the state with respect to punitive damages, because, according to your trial plan order, the compensatory damage award is the predicate for the punitive damage award for the class.

Now, while Dr. Petty and Dr. Burns are both pulmonologists, their backgrounds and experience are very different. Dr. Petty has actually run an addiction clinic where he was treating nurses for addiction, and he has that particular expertise. And, of course, Mary Farnan is a nurse.

Dr. Burns has been more of a public health

official and has been intimately involved in the editing and publication of various Surgeon General's Reports; whereas, Dr. Petty has had more of a hands-on clinical practice for many decades.

And, Judge, I consciously try to avoid duplication. For example, although Dr. Petty has had a connection with various Surgeon General Reports to a much lesser extent than Dr. Burns, I'm not going to go into that with him at all.

Now, one of the issues, just as an example, the defense has raised is, they claim that somehow had Dr. Collins diagnosed Mr. Amodeo's throat cancer earlier, his prognosis would have been entirely different. And Dr. Petty is prepared, you know, to testify on that subject, based upon his vast experience in his field.

And in a sense, obviously we view Phase II as somewhat of a continuation of Phase I, where the

same
witness -- some of the same -- not all of them. I guarantee you, not all of them -- where some of the same witnesses are basically completing their testimony, by now focusing on two individuals, rather than speaking generically.

You know, it's clear from the objections, and Your Honor's rulings on the objections, that when a

witness -- that when Your Honor feels a witness is straying beyond just a sentence or two about Phase I, you know, you cut him off. So, you've made the ground rules pretty clear.

But we think it's perfectly appropriate to say, in effect, to Phase I experts, such as Dr. Petty:

You testified before the jury that smoking causes lung cancer and that smoking causes throat cancer, and now you've reviewed the medical records of two individuals, and we want to zero in on these two individuals.

But, fundamentally, I mean, we have -- we have relied, in lining up witnesses, on our understanding that the same rules would apply in Phase II, and we would have two experts per specialty, you know, leaving out -- we didn't have the issue of treating physicians.

And I'm pretty sure, Judge, we've deposed at least two experts per specialty for the defense. I mean, that's what they're doing. They're listing two experts. And, again, we're involved in a semantical kind of thing here.

And as a practical matter, Judge, we're only talking about a few more independent experts. And if today was any example, where a board-certified expert, you know, finishes up in far less than a day, we're

moving. You know, we're moving.
And I'm going to make every effort to move even more quicker and have back-up if we finish -- I don't think we're going to be in the situation as we were basically just about every day in Phase I. You know, we never had more than one expert per day, and I think here it's very possible that if not two experts, you know, one expert and some lay witnesses. Probably we're talking about half the experts we called in Phase I.
And Dr. Petty is our second pulmonologist.
So, if we're bound by the Phase I ground rules -- and I submit, we had -- we had a right -- a right to rely on that -- now, they'll probably bring up Dr. Feingold, but Feingold is in a -- he did not testify in Phase I.
Feingold is a local pulmonologist. If they want to get into that, they will admit that Feingold's role was totally different, because he interviewed these people, had hands-on contact with Mr. Amodeo, and that's an issue, you know -- we'll deal with that at the time.
At this point, I'm not 100 percent sure I'm calling Feingold. And if I do, they'll -- you know, they'll make their objection. But, obviously, he's a pulmonologist. But we think very, very different from either Burns or Petty.

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But where the case stands right now, we've only had one pulmonologist testify; that was Dr. Burns.
And now we're bringing in our second pulmonologist, Dr. Petty, which would have been perfectly

acceptable
in Phase I, and that's what we're assuming is the case
in Phase II.
MR. REID: The claim that this is somehow on
behalf of a state-wide class and there are a lot of
potential class members, and, therefore, the cumulative
testimony should be permitted, it's just not a valid
point.
This is a -- this particular trial is about
these two individuals, and the jury is going to decide
whether or not these two individuals have a disease,
specifically, which cause is caused by smoking, and
they're going to decide other things relating to these
two individuals. And the witnesses being put on the
stand are only talking about these two individuals,
based on the Court's previous rulings.
So, the fact that we're doing this in the
context of a class doesn't mean that you get to throw
out the rules and you get to put on -- for instance,
would counsel argue that he could put on testimony
about heart disease now from a cardiologist because
there might be a class member out there with heart

disease? Of course not.
So, the fact that it's a class -- and there
is no impact on what these witnesses are testifying to.
These witnesses are specific causation witnesses about
the medical condition of these two plaintiffs. And
that's not going to apply to anybody except for these
two plaintiffs.
Trying to distinguish between Burns and
Dr. Petty, because Dr. Burns was more involved in the
Surgeon General's Reports than Dr. Petty, well, they
were both involved in the Surgeon General's Reports,

12 but that's not a valid reason. The fact -- even if one
13 had never heard of the Surgeon General's Report,
14 they're being called on -- that was Phase I, talking
15 about the Surgeon General's Reports and about general
16 cause and what the Surgeon General did. The witnesses
17 wouldn't even be allowed to discuss -- and Dr. Burns
18 didn't talk about the Surgeon General's Report as his
19 direct testimony, with regard to these two individuals.
20 So, the fact that they both had something to
21 do with the Surgeon General's Reports, the fact that
22 there's a two-expert rule, the problem we have, Your
23 Honor, is if there is a two-expert rule, we're now on
24 the fourth expert about -- talking about the very same
25 subject.

1 You shouldn't be able to have it both ways.
2 If you are going to say I can bring a pulmonologist to
3 talk about the pulmonologist area and have two experts,
4 then you shouldn't be allowed to bring a pediatrician
5 and a molecular biologist to testify to the very same
6 testimony.
7 And if you look at what's in our motion, this
8 is going to be exactly the same testimony that the jury
9 has already heard. There's nothing unique about
10 Dr. Petty. You permitted Dr. Richmond to testify
11 because the Court found, after voir dire, and you
12 permitted Dr. Burns to testify, because you found, by
13 voir dire, that both had some experience in the area of
14 addiction.
15 You remember Dr. Burns talked about treating
16 people; that he had actually treated some people for
17 dependence, and that was part of his proffer. Now
18 counsel argues because Dr. Petty treated people for
19 addiction, he should be allowed to be cumulative.

It boils down to, Your Honor -- in Phase I -- this is not a continuation of a particular witness, because under that argument, every single witness could come back. We had probably nine witnesses or 12 witnesses that testified lung cancer is caused by smoking.

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Counsel could never suggest that every one of those witnesses should be allowed to come back and complete their testimony about individuals. There has to be some limitation.

And there's certainly no prejudice to the plaintiffs here. The plaintiffs have put on three separate doctors, all of whom have testified, with the exception of Dr. Sidransky -- he didn't go to the addiction question -- with the exception of that, all three have already testified to the very issue that this jury has to decide.

And now Dr. Petty is going to be a fourth to say the same thing. And Dr. Petty didn't look at the slides. He didn't look at the X-rays. He didn't do anything different than what the other ones did.

He's coming in, once again, as a record-reader for the jury. And that's the only difference. And at some point the prejudice becomes overwhelming.

The jurors sometimes, I think -- I've had experience over the years where courts have told jurors, you know, the number of experts that people call shouldn't be a factor and so forth, but there gets to be a point where you just bring it over and over and over, and it can't help but affect the jury when they

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bring these people back over and over and over.

So, I would suggest that, once again, we

not
be permitted to hear the same testimony, just from a
different doctor who's from a different part of the
country, and then counsel, of course, in his argument
is already anticipating that he's going to come up with
a different reason for Dr. Feingold, another
pulmonologist, but we'll argue about that if we ever ge
to that.
The bottom line, Your Honor, is there's no
basis for permitting Dr. Petty to come in and to merely
draw the same conclusions that the other doctors have
drawn from reading the same records.
I think Mr. Webb wants to make a particular
point.
MR. WEBB: Just on one point, Your Honor.
Mr. Rosenblatt -- I didn't plan on arguing
this, Your Honor, but Mr. Rosenblatt just disclosed
another opinion that has never been disclosed to us
until this moment.
Dr. Petty was disclosed in an expert
disclosure, and has been deposed on his opinions, about
whether smoking caused the diseases of Mr. Amodeo and
Mrs. Farnan, and he was deposed as someone who would
testify on the addiction of Mrs. Farnan and Mr. Amodeo

to nicotine. And he has been deposed on that, although
it is subject to obviously the cumulative motions just
made.
Mr. Rosenblatt just talked about a brand new
opinion in which he said that Dr. Petty is now going to
offer medical opinions on whether Dr. Collins'
malpractice could have affected Frank Amodeo's
treatment. That gets in -- there's a whole area of
this case dealing with the size of Mr. Amodeo's tumor
in January of 1987, when he first consulted with

Dr. Collins, versus the size of it in June of 1987 when he was properly diagnosed with laryngeal cancer.

I, on behalf of the defendants, Your Honor -- that opinion, which I just heard about three minutes ago, five minutes ago, we make a motion in limine on that opinion. We couldn't possibly cross examine Dr. Petty. He hasn't been disclosed on that issue. He's not been deposed on that issue, and I respectfully suggest to the Court that he should not be allowed to offer an opinion -- an expert opinion on a subject matter that he was never disclosed on, nor ever deposed on.

MR. ROSENBLATT: On that last issue, Judge, I mean, how can they -- how can they dream, when they depose a doctor for hours, and who's going to obviously

testify that, in his opinion, cigarette smoking caused Mr. Amodeo's throat cancer, and not get into the issue of if Collins had made the correct diagnosis, would it have changed anything? I mean, that's just part of the -- in a disclosure, you're not laying out every little fragment and sentence.

I mean, that's obviously part of the picture. That's part of the hypothetical: That he went to a doctor; he had these complaints; he saw him in January; the diagnosis wasn't made until June. Does that matter?

So, it's all just part of the picture. It's just a simple thing where the witness is coming in: What's this case all about? What caused the lung cancer? What caused the throat cancer? Were these people addicted?

THE COURT: Did they ask him the question on deposition?

MR. ROSENBLATT: I'm sure it was gone

into.
MR. WEBB: No, it wasn't. No.
MR. ROSENBLATT: I'm sure -- I'm sure the subject of what Dr. Collins did or didn't do, you know, came up. I don't -- I don't have --
MR. WEBB: Not only -- I don't want to interrupt you.

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MR. ROSENBLATT: Well, if it didn't come up, it should have. I mean, if it didn't come up, it certainly should have: Do you have an opinion on anything Collins did or didn't do?
I mean, again, Judge, we're strictly in this area of game-playing, where if it didn't come up, they're obviously smart enough that they deliberately made a decision to avoid that subject so they could make the argument they're making today.
The man is in front of them. They're in Colorado. They're taking his deposition about Frank Amodeo. How do you depose an expert in the Amodeo case without discussing this delay in diagnosis and seeing what opinions the doctor has?
THE COURT: All right.
MR. WEBB: Can I respond to that just briefly, Your Honor, only because I just want to make sure the record is clear.
Not only was Dr. Petty not deposed on that, it happens to be that Dr. Collins' medical records were never turned over to Dr. Petty.
There are Dr. Collins' medical records in January. They happened to have been excluded from the records that were turned over to Dr. Petty by Mr. Rosenblatt's office.

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And there is no -- there's -- there is no relationship at all -- whether smoking caused the laryngeal cancer, that is an issue in this case. But a

totally separate issue is whether or not the malpractice -- the size of the tumor in January exacerbated the injury or caused the injuries that he's complaining about in this case is a completely separate -- it's a completely separate medical opinion that has nothing to do with the first issue, nothing at all.

So, not only was he not disclosed on it, but we didn't ask the question on it not because of any strategy. I didn't dream until this moment -- by the way, Dr. Burns did not opine on that, nor did Dr. Richmond opine on that. So, the fact that now they say Dr. Petty is going to opine on that issue not only comes as a surprise, but they didn't even disclose Dr. Collins' records to him. So, that would be extremely unfair to have him testify about something never disclosed at all.

MR. ROSENBLATT: It's our position, we would have the right to ask a hypothetical question to any expert: Assume such and such; do you have an opinion whether that had an impact one way or the other?

It's hardly -- he doesn't have to see all of

the records about wood dust and saw dust. Make a hypothetical. And what counsel has just said is he's cross examined every -- every witness. Rosenblatt just sent you selected records, and this is just another example of what he would do on cross. It hardly provides a basis, you know, to exclude someone.

But more fundamentally, Judge, just simply following the -- there has never been an announcement by the Court -- to my knowledge, they've never asked you for an announcement, because they were afraid to, because then you would have remembered and you would have explicitly, well, discussed at least: Are we operating under the same rules as Phase I? They avoided that to come in and make this cumulative

argument.
THE COURT: Well, nonetheless, he's on his way in, so there's not much we can do about that right now.
MR. ROSENBLATT: Right.
THE COURT: In the event the Court agrees with the defense -- and you have him scheduled for tomorrow?
MR. ROSENBLATT: Tomorrow morning.
THE COURT: Then what would happen?
MR. ROSENBLATT: I think I have some back-up

lay witnesses, but they'll probably be very brief, so we'll have another short day.
THE COURT: We'll think about that anyway. We won't know until tomorrow morning, anyway.
All right. Okay. We'll be in recess until tomorrow.
(Court was adjourned at 3:50 p.m.)